EC-2

Hawaii Employer-Union Health Benefits Trust Fund

ENROLLMENT FORM FOR RETIREES

Customer Service Phone: 586-7390 or toll free 1-800-295-0089

1. Event:

2. Event Date: (MM/DD/YY)

See Instructions on reverse side BEFORE completing this form.

3a. Retiree's Last Name, First, M.I.			3b. Social Security Number:	
3c. Mailing Address:			3d. Birth Date: (MM/DD/YY)	3e. Marital Status: ❑ Married ❑ Single
3f. City:	3g. State:	3h. Zip Code:	3i. Phone Number	3j. Gender: ❑ Male ❑ Female

4. If your **spouse** is a State or County – Employee or Retiree please enter their Social Security Number.
Spouse Social Security Number: _____ / _____ / _____

5a. Dependents: First Name, M.I., Last Name	5b. Birthdate (MM/DD/YY)	5c. Social Security Number	6. Relationship	7. Gender	8a. Add	8b. Delete
				M or F	❑	❑
				M or F	❑	❑
				M or F	❑	❑

9. Plan Selections, Changes or Cancellations
a. Make your selection by checking the box(es) for the appropriate benefit plans below.
b. Select either Self, Family or Cancel/Waive coverage.
c. Choose only one box in each plan section.

Plan Section	Carrier Selection	Self	Family	Cancel / Waive
Medical / Drug	HMSA PPO Medical and Drug Kaiser Medical and Drug	❑ ❑	❑ ❑	❑
Dental	HDS Dental	❑	❑	❑
Vision	VSP Vision	❑	❑	❑
AETNA Life Insurance Plan (Retiree Only)		❑		❑

10. Medicare Part B

a. ❑ I am enrolled in Medicare Part B and I have attached proof of Medicare Part B enrollment

b. ❑ My **spouse** is enrolled in Medicare Part B and I have attached proof of Medicare Part B enrollment

Spouse's Signature _____

Spouse Signature Date _____ / _____ / _____

11. Certification (see instructions on back of this form)

Retiree's Signature: _____ **Date:** _____

For EUTF Use Only (DO NOT WRITE BELOW HERE):

12. Dept. ID#	13.Code	14. Retirement Date:	15.BU: ____ ____
16. RET Elig for Reimbursement on		17. SP Elig for Reimbursement on	
18. Survivor of:		19. RET SSN	20.

Fax to 808-586-2161 OR **Mail** to EUTF, P.O. Box 2121, Honolulu, HI 96805-2121 OR **Deliver** to 201 Merchant Street, Suite 1520.

INSTRUCTIONS FOR COMPLETING EC2 FORM

A. Print or type **clearly**, if form is unreadable it may be sent back to you.
B. **Please submit form to Hawaii Employer Union Health Benefits Trust Fund (EUTF)**
C. Sections:
   1. Event – Enter a qualified event

New Retiree	Delete Dependent	Medicare Part B
Marriage	Medicare Eligible	
Divorce	Surviving Spouse / Child	
Death of Spouse	Change Address	
Add Dependent	Other	

   2. Event Date – Enter the date of the Event
   3. Enter Last Name, First Name, M.I., Social Security No., Date of Birth, Gender, Marital Status, Daytime/Evening Phone Number, Mailing Address, City, State and Zip Code in the appropriate spaces.
   4. Enter spouse's Social Security Number if spouse is a state or county employee or retiree.
   5. Enter Dependent(s) Name, Birth date, and SSN.
      If listing more than 3 dependents, write "Continued" on the last line of the Dependent section. Use a separate of paper to list additional dependent(s) information.
   6. Use the following codes for Relationship column:
      SP = Spouse **CH** = Child **DC** = Disabled Child√√
      DP = Domestic Partner√ **DPC** = Domestic Partner Child√
      For Relationship codes with √ and √√, please see below for other EUTF required forms.
   7. Gender – circle either M or F.
   8. Check add box to add dependent, check delete box to delete dependent.
   9. **Plan Selections** (See Reference Guide for Plan Coverage Details).
      Check the appropriate boxes to select your medical, dental and vision plans.
   10. **Proof of Enrollment in Medicare Part B**– In accordance with Hawaii State law, Retiree and/or their spouse are required to enroll in Medicare Part B in order to maintain EUTF Health Insurance Benefits. Please check the appropriate boxes and provide us a copy of your and/or your spouse's Medicare Card or official Medicare letter as proof of Part B enrollment. When we receive a copy of you and / or your spouse's Medicare Part B card, you will be eligible for the State's Medicare Part B premium reimbursement program.
   11. **Certification**
      Signature of Retiree certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected.
      Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student.
      Please enter date of Retiree's signature.

Sections 12. to 20. Reserved For EUTF OFFICE USE ONLY

Other EUTF forms to include with EC2 (if applicable):

√Domestic Partnership Declaration or Termination
√Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
√√D-1 (5/2003) for enrolling disabled child
Proof of Medicare Part B enrollment
Life Insurance Waiver Form (If waiving life insurance)
AETNA Life Insurance Designation of Beneficiary (If enrolling for the first time or changing beneficiaries)

Reference material to be used when completing this form

Reference Guide for Retirees
Retirement Health Insurance Benefits Information Booklet

Keep a copy for your reference